Literature Review and Findings: Implementation of Waiver Policies

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- *Design and implementation of health information systems for disease surveillance.*
- *Delivery of quality services by health workers.*
- *Availability and appropriate use of health commodities.*

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Abstract

Many countries are adopting user fees as part of their national strategies for financing for public health care. While these fees generate funding, they can also deter poor and vulnerable groups from seeking care in a timely manner. In an effort to protect these groups and allow them fuller access to health care, many countries, including Zambia, have instituted policies to excuse the groups from paying fees. In practice, however, these exemption (for characteristic targeting of groups, based on age, disease, employment, or other characteristics) and waiver (for targeting individuals, based on ability to pay) policies often do not produce the desired results, because they lack clear and consistent procedures for implementation and evaluation, and funding to reimburse providers who provide care to the target population. The current review, done by Partners for Health Reform*plus* at the request of USAID/Lusaka and the Zambia Integrated Health Program, looks at literature regarding these policies, with a focus on seeking out country-specific examples of individual, need-based waivers. The review found that evaluations that have been done focus on components of the implementation process, rather than on quantitative analysis linking implementation and its effectiveness in reaching the poor. However, some general conclusions and recommendations are supported by the literature: Waivers are most appropriate for higher-cost services. In addition, there must be simple waiver policies and guidelines that are clearly communicated to health care providers and beneficiaries, a funding mechanism to reimburse providers, and a system for monitoring and evaluating the waiver program to ensure it produces the intended outcomes.

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
BPS	*Biro Pusat Statistik* (Central Bureau of Statistics)
CBOH	Central Board of Health
CPC	Commune People's Committee
DHMT	District Health Management Teams
HCCS	Health Care Cost Scheme
HIV	Human Immunodeficiency Virus
IDT	*Inpres Desa Tertinggal*, Villages Left Behind (Poor Villages)
KNH	Kenyatta National Hospital
LIC	Low Income Card
MCDSS	Ministry of Community Development and Social Services
MOH	Ministry of Health
NHIF	National Hospital Insurance Fund
STD	Sexually Transmitted Disease
USAID	United States Agency for International Development
WWAC	Ward Welfare Assistance Committee

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Executive Summary

The purpose of this review is to gather country examples on individual need-based exemption implementation strategies and to draw out lessons learned from the literature. This literature review was conducted at the request of the United States Agency for International Development (USAID)/Lusaka and the Zambia Integrated Health Program. While Zambia has an established policy of waiving user fees for those who are unable to pay, in practice there is little knowledge, and inconsistent implementation, of this policy.

User fees are often one of the components of national strategies for financing health care services. Although user fees can be used to generate income for drug purchases or to help fund a health facility, it can also deter people from seeking care in a timely manner. Exemptions and waivers can facilitate people's access to care by eliminating fees for those who are most vulnerable. The most vulnerable can be those with greater health care needs such as children under 5, or exemptions can target priority public health interventions, such as immunizations. Waivers can be used to protect the people who cannot afford to pay fees. Exemptions and waivers can increase the use of health services, allowing the population to realize the value of health services (Newbrander et al., 2000).

The literature makes a distinction between exemptions and waivers: exemptions are granted based on characteristic targeting, while waivers are granted based on individual targeting. This review focuses on implementation of individual targeting (waivers). Characteristic targeting exempts certain groups of individuals based on characteristics such as age, disease, or employment, while individual targeting takes into account each individual's ability to pay. Characteristic targeting may result in high levels of undercoverage and leakage, but it is easy to administer. Undercoverage occurs when some of the poor do not receive waivers as intended, while leakage occurs when the non-poor receive free services. Individual targeting in theory would minimize undercoverage or leakage problems, but in practice its administrative difficulties may also lead to similar results.

Upon reviewing the reports and publications found, it became apparent that there was a limited amount of information available on specific steps to implementing an exemption policy. Many reports were evaluations that assessed user fees where exemptions were included in the discussion but were not the focus of the findings. It was also found that while many countries had policies to exempt fees for the poor, few had in place established procedures to implement the policy. The most concrete documentation comes from Indonesia and Thailand, with some limited experience in Zambia and other African countries.

The literature review did not reveal empirical data regarding how to implement waivers (need-based exemptions) most effectively. Systems for monitoring the effectiveness of waivers are weak, and few evaluations have been done. The evaluations that have been done focus on qualitative information about the implementation process, which is what this paper has focused on, rather than quantitative analysis of implementation components and effectiveness. Given the information constraints, several conclusions are generally supported by the literature:

- There must be clear and simple waiver policies and guidelines for granting waivers to the poor. The guidelines should be set at the national level to ensure adequate consistency

between districts and communities, while providing sufficient flexibility at the sub-national levels to be locally applicable and accepted.

- Resources must be dedicated for educating the beneficiaries and health staff on the waiver policies. Lack of clarity and knowledge was an issue cited in nearly every study published and should be a key component of any implementation plan. Dissemination of policies and procedures to consumers must include a variety of communications channels, not relying solely on health facilities and their staff.

- The lack of a reliable funding source to pay for the services provided to the poor negatively impacts the motivation (and sometimes financial ability) of health staff and health facilities to grant waivers. Given funding constraints, it may be necessary to limit the number of waivers granted, or to provide guidance on the percentage of the population that can be granted waivers, in order to ensure adequate funding for services provided to the poor.

- There is a tradeoff between undercoverage and leakage, and neither is completely avoidable. Policies can be established that encourage erring on one side or the other. Communication of clear policies to all involved, and a mechanism for regular evaluation, can help to minimize undercoverage and leakage.

- Using multiple targeting methods may be a more efficient way to administer a targeting program and achieve desired outcomes. Using geographical targeting (characteristic) to identify lower income areas, combined with direct targeting within those areas may allow relatively high accuracy at relatively low cost.

- Means testing should be used only in waiving fees for high cost services, because there is a high administrative cost. Waivers should be discouraged for low-cost services, relying on exemptions to ensure access to services.

- Once an individual is granted a waiver status, there should be a clear policy regarding the duration for which the waiver status is valid. Setting a regular review period helps to minimize leakage and undercoverage.

- Routine monitoring and evaluation is required to ensure that a system has the intended outcomes, particularly with respect to the level of leakage and undercoverage. Ongoing implementation and design changes may be required to ensure that the poor are adequately covered.

Based on the literature, there are many problems with the current state of the waiver system in Zambia, including lack of knowledge by health workers and the general public, lack of clear implementation guidelines (how to define the poor, who has authority to waive the fee), lack of a payment mechanism, and lack of an evaluation system. In addition to the conclusions above, recommendations are offered for Zambia as it reconsiders the future of its waiver policy:

- Determine the extent to which characteristic exemptions are covering the poor at the primary health care level. Based on that data, determine whether waivers should continue to be implemented at the primary care level and what is required to strengthen the waiver system, or whether the waiver system should be discontinued at the primary care level.

- Commit resources to providing health care for the poor by setting aside a budget for reimbursing health providers for care to the poor. Based on the budget available, determine

the number of people or percentage of the population that can be granted waivers. If the budget is limited, consider implementation in a limited area.

- Prepare a plan for implementation, and commit funding to implementation activities. The evidence shows that mere statement of policies does not produce the desired results in any country studied.

1. Introduction

The purpose of this review is to gather country examples on individual need-based exemption implementation strategies and to draw out lessons learned from the literature. This literature review was conducted at the request of USAID/Lusaka and the Zambia Integrated Health Program. While Zambia has an established policy of waiving user fees for those who are unable to pay, in practice there is little knowledge, and inconsistent implementation, of this policy. Zambia also has set age- and disease-based exemptions, which are adhered to generally. It is anticipated that these findings can help Zambia to improve its mechanisms for ensuring that everyone has access to health care, regardless of ability to pay.

Research databases such as Medline, USAID Clearinghouse, Partners for Health Reform*plus*' resource center, the World Bank, development organizations' databases, and other electronic databases such as Emory University's MedWeb and Health InterNetwork were utilized. The descriptors exemption, user fees, and health care financing were used in the search. All countries were included in the search and a limitation on publication dates was not set.

Upon reviewing the reports and publications found, it became apparent that there was a limited amount of information available on specific steps to implement an exemption policy. Many reports were evaluations that assessed user fees where exemptions were included in the discussion but were not the focus of the findings. The evaluations looked at already existing situations where exemptions have been practiced. They discussed reasons why exemptions were not effective, different types of exemptions, disadvantages and advantages of various exemptions, where patients can find exemptions, and different obstacles and difficulties the patient faces.

It was also found that while many countries had policies to exempt fees for the poor, few had in place established procedures to implement the policy. The most concrete documentation comes from Indonesia and Thailand. There is limited experience in Zambia and other African countries, as discussed in this review.

This review found that there is a lack of clear analysis linking implementation components with effectiveness of exemption or waiver systems, and a general lack of documented effectiveness. Some issues, such as the periodicity of re-validating need-based exemption, or the mechanisms for funding the services for the exempt, receive little attention in the literature. The information gathered here, based on the available literature, is descriptive of the experiences and procedures, with some anecdotal analysis of the results.

2. Background

User fees are often one of the components of national strategies for financing health care services. Although user fees can be used to generate income for drug purchases or to help fund a health facility, it can be an additional barrier for the poorest population. User fees can deter people from seeking care in a more timely manner because of the lack of funds to pay for care. Given that one of the ultimate goals of financing reforms is to improve people's health, there must be a system for ensuring that those unable to pay have access to health services.

Exemptions and waivers can facilitate people's access to care by eliminating fees for those who are most vulnerable. The most vulnerable can be those with greater health care needs such as children under 5, the elderly, or those with compromised immune systems. Or, exemptions can target priority public health interventions, such as immunizations or treatment of sexually transmitted diseases. Exemptions can also be used to protect the people who cannot afford to pay fees. Those who previously had limited access to care, or delayed care seeking, may be covered under certain exemption categories. Exemptions can increase the use of health services, allowing these populations to realize the value of health services (Newbrander et al., 2000).

3. Zambia Context

3.1 Cost Sharing in Zambia

Cost sharing, or user fees, was introduced in Zambia in the early 1990's as part of a package of reforms of the health sector. Cost sharing was seen not only as a means for raising revenue, but also as a way to increase community participation in the delivery of health services and to create greater accountability from health care providers. Another key component of the health reforms was decentralization of management to the districts. As a result of decentralization, districts have significant autonomy in implementation of cost sharing. The district health management teams (DHMTs) set guidelines for cost sharing and establish a range of acceptable fees and the types of cost sharing allowed. Most decisions are made without the input of the community, so there is little sense of ownership in the cost sharing system.

Cost sharing fees vary widely from district to district. The mean fee for an adult at a health center was Kwacha 800, and K. 1,100 at a hospital in 1998 (at the time of the study, US$1=K. 1725). It is estimated that cost sharing revenues account for approximately 10.0 percent of operating costs, excluding salaries and drugs (Daura et al., 1998). More detail on average fee levels is provided in Table 1.

Table 1: Cost Sharing Fees in Zambia

	Mean Fee
Health Center Fee – Adult	K. 813
Health Center Fee – Child	K. 629
Hospital Fee – Adult	K. 1,139
Hospital Fee – Child	K. 754
Cost Recovery Ratio	10.0%

Source: Daura et al, 1998.

Prepayment schemes were introduced in 1993/94 and are currently operational in several districts, including Lusaka and Kitwe. Prepayment schemes allow an individual to pay a fixed monthly fee, in exchange for free services when the person falls sick. Prepayment schemes have been both hospital and health center based. Official policies had suggested a preference for prepayment schemes, and recommended that prepayment premiums be set lower than user fees (CBOH, 1999). According to the Central Board of Health (CBOH) guidelines, people may pay their premiums on a monthly, quarterly, or yearly basis depending on what best suits the local residents' income patterns. If people are allowed to join at any time, however, then a waiting period of one month before eligibility for services is recommended.

Evaluation of prepayment schemes in Zambia found many problems including adverse selection and abuse of the scheme. In Kitwe and Lusaka, it was found that the waiting period between joining

the scheme and eligibility for services is only 24 hours, so many people joined the scheme only when they were sick (Daura et al., 1998). People also shared cards, because it was difficult to verify the identity of the insured.

As an alternative to the prepayment scheme, which includes an insurance component, discount cards have been piloted in a few districts. Discount cards do not include any risk pooling element, and are simply a mechanism for people to prepay for a fixed number of health center visits when they have cash. A thorough evaluation of discount cards as a cost sharing option has not been conducted.

3.2 Waiver and Exemption Policy in Zambia

Recent policy on Zambia's cost sharing scheme states that "No one in critical need of care should be turned away." The Ministry of Health's (MOH) current official exemption policy identifies the following services to be provided free of charge:

- Treatment of chronic illness such as Tuberculosis (TB), HIV/AIDS
- Treatment of Sexually Transmitted Diseases (STDs)
- Treatment of epidemics such as cholera
- Safe motherhood and family planning services

In addition, the following groups are to receive free health services:

- Children under 5 years of age and people over age 65 years
- Vulnerable individuals with evidence from the Ministry of Community Development and Social Services (MCDSS) indicating that they cannot afford to pay

Age-based exemptions were introduced in 1994 to protect young children and the elderly. In a study using the Living Conditions Monitoring Survey data, Diop et al. (1998) found that 24 percent of people accessing public institutions were wrongly denied exemptions. The socioeconomic distribution showed that 46 percent of exemptions were granted to patients among the 40 percent lowest income groups, while patients in the top 40 percent income categories received 31 percent of the exemptions. The rural population received a relatively larger proportion of the exemptions – receiving 70 percent of exemptions while they represented 66 percent of the patients. The study found that "demographic-based exemptions in government health institutions contributed to categorical equity, and the distribution of medical benefits through these exemption measures is relatively progressive" (Diop et al., 1998).

Daura et al. (1998) found that people were well informed about the age-related exemptions, and that service related exemptions were also reasonably well known and enforced. However, there was little knowledge of the need-based exemptions or waivers. In some cases, health staff did not accept exemption certificates issued by the MCDSS, and the limited MCDSS funds that were transferred to the DHMT for exempted persons did not filter to the health center (Daura et al., 1998). Masiye and Odegaard (2000) found that in 1999 there were 15,589 beneficiaries of the official need-based exemption scheme, which represents 0.16 percent of the overall population.

While the official exemption policy was only benefiting a few people, many more people were being exempted due to inability to pay. Three-quarters of districts allow health staff to use their discretion in exempting patients from payment (Daura et al., 1998). Of 30 responding districts, eight estimated that fewer than five percent of patients received exemptions due to inability to pay, while five estimated that more that 35 percent of patients were unable to pay.

The large majority of need-based fee waivers are authorized by health staff with minimal guidance and oversight. Studies of cost sharing practices generally find that health facilities maintain little data on who receives these waivers, so it is not possible to evaluate whether the poor are benefiting. There is also evidence that the poor sometimes do not receive care because they are unable to pay (Daura et al., 1998).

In the current decentralized health sector, districts are exploring and implementing various innovative cost sharing mechanisms, but giving relatively less focus to improving waiver mechanisms to ensure that the poor have access to health care. Additional guidance and support to the districts is needed in implementing effective mechanisms for protecting the poor.

4. Definitions

A number of terms are used when discussing exemptions and user fees in the context of health care financing. A few of the more common terms are listed below (Newbrander et al., 2000, Newbrander et al., 2001).

Characteristic targeting – Characteristic targeting provides people with certain features or specific illnesses or diseases, free or reduced-price health care, regardless of income level. This type of targeting does cover some of the poor but does not directly target the poor for benefits.

Individual or direct targeting – Individual targeting allows people who have low incomes to receive free care or care at a reduced price. Qualification for free or reduced care is determined through means testing to demonstrate that an individual or family earns below an income level predetermined by policy. Although more expensive to administer, direct targeting can avoid exempting the non-poor and reduce leakage.

Exemption – A form of targeting where the services are automatically free because of the desire to encourage people with certain characteristics to use certain health services. Because it is automatic, it usually involves minimal decision making at the facility.

Waiver– A form of direct targeting when a fee is eliminated or reduced for a person who cannot afford to pay a user fee for a service. Usually determined by the health facility or in the community by using means testing.

Means testing – A process of determining a person's ability to pay, for the purpose of providing free or reduced-price services to those who cannot pay the full price of services.

Undercoverage – Occurs when the poor do not receive benefits intended for them and either have to pay for care or do not use it at all.

Leakage – Occurs when the non-poor receive benefits that were intended for the poor, resulting in the problem of charging people less than they can afford to pay.

Effectiveness – The ability of waiver and exemption mechanisms to ensure that those who were intended to receive the benefit of not having to pay for health services receive that benefit and that those for whom the benefit was not intended do not receive that benefit.

Through the remainder of this paper, exemption and waiver will be distinguished as defined above. Tradeoffs between undercoverage and leakage will be discussed, as they relate to the cost of administering exemptions and waivers and the overall effectiveness of targeting mechanisms.

5. Characteristic vs. Individual Targeting: Advantages and Disadvantages

As defined above, characteristic targeting results in an exemption, and individual targeting results in a waiver. Selection of characteristic or individual targeting determines the complexity of the targeting system.

Individual or direct targeting takes into account what each person or family is able to pay for health care services. This decision is made by the use of means testing. Means testing relies on quantitative and/or qualitative information to determine if an individual qualifies to receive free services. It is usually conducted in the form of a questionnaire where the individual is interviewed at a health facility or other point of service delivery. Cross-sectoral means testing, whereby an individual is qualified for free health care as well as other services, is an alternative to means testing at the health facility. The extent of the questions can simply be to determine if they are qualified or to classify them in a specific category. The latter would require more detailed questions. Means testing is more accurate overall in distinguishing the poor from the non-poor. However, the drawback is its expense and complexity, making direct targeting more difficult to administer and implement.

Characteristic targeting on the other hand is easier to implement. However, it does not necessarily protect just the poor. Characteristic targeting exempts certain groups of individuals based on characteristics such as age, disease, employment, or geographic location. Since the non-poor can fall into one of these categories there is the likelihood that some leakage will occur. At the same time, there may also be undercoverage as some of the poor may not fall into one of the exempt groups. "As a rule of thumb, if more than half the people who use the service are poor, then characteristic targeting would appear to have a positive impact from an equity viewpoint as well as from a public health perspective" (Newbrander et al., 2000). For example, if the majority of the individuals who require nutritional supplements are poor, then it should be provided free of charge. This rule of thumb provides guidance on which health services should be exempted from fees, but does not explain how best to target the poor for other health services.

Characteristic targeting encompasses what is sometimes referred to as self-targeting or self-identification. Self-targeting can take place by operating a free facility in a very poor area. The poor, who are the targeted group, will use services there, whereas the non-poor will demand services elsewhere (Bitran, 2001). This example is equivalent to targeting by geographic characteristics. Self-identification can also be implemented by providing services that are disproportionately demanded by the poor for free. Self-identification, like characteristic targeting, entails no specific effort made by any organization or the government system to find eligible people.

Characteristic targeting can also be used in combination with direct targeting, as in the case of Indonesia. The *Kartus Sehat*, or free health card program, gives poor families a card that allows them to receive care at no charge. The card allows up to eight members of the family to be included. They must initially visit the health center closest to them and if further treatment is needed, the Kartus Sehat, plus a referral letter will give them access to free care at a public hospital (Gibbons, 1995). The distribution of the Kartus Sehat is prioritized by *Inpres Desa Tertinggal* (IDT) villages ("villages left

behind," or poor villages) predetermined by the *Biro Pusat Statistik* (BPS, Central Bureau of Statistics). All of the IDT villages in a district receive the Kartus Sehats first, then they are distributed to the poor in the rest of the villages. Geographic and individual targeting takes place since priority goes first to the IDT villages and among those the poorest within the village are selected – the whole IDT village does not receive the Kartus Sehat (Gibbons, 1995).

Combining characteristic and direct targeting can help to increase accuracy of targeting at relatively low cost (Willis, 1993). Willis suggests that the leakage caused by offering free services in poor areas could be minimized by requiring civil servants and others known to have relatively high incomes to pay (Willis, 1993). While this particular scenario may not be politically feasible, combining characteristic and direct targeting may be more efficient than relying on one method alone to protect the poor.

Characteristic targeting may result in high levels of undercoverage and leakage, but it is easy to administer. Individual targeting in theory would minimize undercoverage or leakage problems, but in practice its administrative difficulties may also lead to similar results. The discussion of implementation below seeks to draw out some lessons learned from other countries regarding how to administer direct targeting.

Table 2 summarizes the features of direct and characteristic targeting, including the advantages and disadvantages of each. Neither targeting mechanism is universally more preferable – the choice between characteristic and individual targeting depends on the country environment, the goal of targeting (promoting use of a particular service, protecting the poor, etc.), and tolerance for leakage or undercoverage.

Table 2: Direct vs. Characteristic Targeting

Feature	Direct Targeting	Characteristic Targeting
Population targeted	Poor individuals	Individuals of specified target groups
Qualification for reduced or no fees	Determined by income level	Determined by individual's characteristics
Examples of qualified individuals	Members of poor families	Armed forces Civil servants TB patients Children under 5 Pregnant women AIDS patients
Means of determining qualification	Means test Evaluation by social worker Proxy means test Visual assessment (e.g., of clothing or housing) Certification by village elder or chief	Age (under 5 or elderly) Geographical residence Employment (military, civil service) Nutritional status (at-risk child)
Result of qualification (term used for receipt of total or partial subsidy)	Waiver	Exemption

Advantages of protection mechanism	Targets the poor directly Reaches the poor more effectively	Requires less information Requires less cost to administer Has less stigma attached
Disadvantages of the protection mechanism	Requires much information Risks missing some poor (potential undercoverage) Risks including some non-poor (potential leakage) Stigmatizes those receiving the waiver May be more bureaucratic and arbitrary	May not exempt all of the poor from paying fees (undercoverage) Exempts many who can afford to pay (leakage) Accrues benefits to the non-poor

Source: Newbrander et al., 2000

6. Framework for Implementation for Individual Need Based Exemption

6.1 Defining/Identifying the Poor

Developing an effective mechanism for defining and identifying the poor is a critical component of a successful waiver system, but is difficult to implement. A cost-recovery study of sub-Saharan Africa found that protecting the poor through exemptions is commonly stated in policy documents. But the definition of "the poor" is rarely clarified (Nolan et al., 1993). Another cross-country study (a survey of 26 countries) found the eligibility criteria to be vague, simply stating that fees should be waived in cases of "financial hardship" (Kenya), for those who are "destitute" (Ghana), or for the "very poor" (Uganda) (Gilson et al., 1997). That study also found that the greatest constraint to effective implementation cited by respondents was lack of information about people's income (see Table 3). Most survey respondents stressed that it was hard to identify the people who should be exempted (Gilson et al., 1997).

Table 3. Key Problems of Exemption Policy Implementation

Problem	No. (%) of respondents (n=18)
Hard to identify people supposed to be exempted	16 (80%)
Providers reluctant to grant exemptions	11 (61%)
Users reluctant to seek exemption	8 (44%)

Source: Gilson et al., 1997

Presently in Ghana, properly identifying the poor has been very difficult for health providers. There were no clear criteria or guidelines available at any of the study sites on how to define the poor. The only quantitative finding from a study that provided demographic background information was that half who were classified as "paupers" spent less than 10,000 cedis/week (US$1.37/week) (Garshong et al., 2001).

Before waivers can be implemented, clear criteria to determine who the poor are should be agreed upon. In some countries these criteria are set at the community or district level. Once there are clear criteria, means testing can be conducted through interviews at the health facility or an application process, involving the community or an outside social welfare agency.

The waiver system can be designed to be either supply or demand driven in its approach to identifying the poor. That is, the system can require a government authority to actively seek out eligible individuals, or it can grant waivers only to those who request them (Bitran et al., 2001). "In Colombia, the Beneficiary Identification System run by municipalities actively interviews all households in their jurisdiction, and selects the ones to enter the Subsidized Regime" (Bitran et al.,

2001). Widespread dissemination of waiver system policies can elicit demand, regardless of whether officials choose to actively seek out beneficiaries.

6.2 Setting Income Criteria for Defining the Poor

Some countries have experience with setting income criteria for identifying the poor. The policy in Zambia includes income as one indicator, along with other indicators presented in the next section. The income threshold for the poorest group Zambia is 15,000 Kwacha per month for an individual (US$3.65). In Thailand, to qualify for the Low Income Card, the income threshold level was 2000 Baht (US$78.34) per month for an individual and 2800 Baht (US$109.67) for a couple (based on 1994 exchange rates). In Zimbabwe the income ceiling that would qualify someone for an exemption was ZWD $400/month (US$61.43 based on 1993 exchange rate of 6.512).

Although these countries have set income criteria, there is still much difficulty in verifying the income levels. In Zimbabwe, income cannot be verified for 62 percent of the workforce who are self-employed or have in-kind incomes (Hecht et al., 1992). There were also problems in using formal income criteria in Thailand (Gilson et al., 1998). Russell and Gilson's cross-country study found that "information on household income sources was…difficult to obtain and verify" (Gilson et al., 1997). While income can be one of the criteria, other guidelines are needed for identifying the poor.

6.3 Using Other Criteria for Defining the Poor

It was found that most countries, including Zambia, used non-income criteria to define the poor. Sometimes the criteria were objective, such as owing debt, not having any land, or owning few assets. In other cases, the criteria were more subjective, such as "appearance of clothes or shoes" (Kenya). A cross-country study found that 12 of 18 respondents reported the appearance of the user as "an important factor influencing the decision to exempt" (Gilson et al., 1997).

In Zambia the eligibility criteria established by the Ministry of Community Development and Social Services includes both income and non-income indicators. A person's economic status is categorized into one of three groups, detailed in Table 4. It is not explicit whether a person has to meet all or some of the criteria within a group. Group 1 and 2 are considered to be poor, but only Group 1 is considered to be the very poor and destitute. Individuals in Group 3 are those who can afford to pay for care. It is not clear whether Group 2 is expected to pay for care.

Table 4: Criteria of Wealth Groups in Zambia

Group 1	Group 2	Group 3
▲ Per capita wage income not exceeding K. 15,000 ▲ Chronic food insecurity ▲ No land or productive assets ▲ Unsupported aged widow, disabled, too old, etc. ▲ Orphaned children ▲ Illiterate and no skills ▲ Depends on erratic help from neighbors, etc.	▲ Per capita wage income not more than K. 40,000 ▲ Depends on peasant agriculture ▲ Occasional food insecurity ▲ Has inadequate income ▲ Runs small family business ▲ Depends on relatively stable help from kin ▲ Has low yield productive or non-productive assets ▲ Semi-illiterate	▲ In stable employment ▲ Has regular income ▲ Runs business enterprise ▲ Has food security ▲ Owns valuable and productive assets

Source: Masiye et al., 2000

In Thailand, the criteria for identifying the poor are developed by each community. The criteria developed by one community are given below for illustrative purposes. Allowing individual committees to establish the criteria for defining the poor helps to ensure that the waiver criteria are appropriate for the local conditions. There is no evidence, however, that criteria developed at the local level correlate more closely with poverty than criteria developed from the central levels. The criteria used by one community to categorize the different economic groups are described in Table 5.

Table 5: Criteria of Wealth Groups in One Community in Thailand

Rich	Medium	Poor
▲ Have a lot of cash, e.g., one case of over 500,000 Baht in cash (savings in bank) ▲ Money lender ▲ Land owner: have 'thousands' of rai ▲ Own a big house, with household consumables ▲ No debt ▲ Good farm output/yield which generates good money	▲ Have own land ▲ Have enough money to support household ▲ Big house ▲ Capable (physically, practically, and mentally) ▲ Government official (e.g., a village teacher; or work in nearby town) (implication is regular salary, social status) ▲ Big land holding but not necessarily cash ▲ Have enough money, and enough to eat ▲ Widow, but with support from children	▲ Landless or owns only very distant and cheap land ▲ Agricultural labourer ▲ Worker e.g., in construction and likely to work outside of village ▲ No possession or assets ▲ Have to borrow money if wish to invest/farm (seeds, fertilizer) ▲ 'Earn in the morning, eat in the evening' i.e., food has to be earned daily ▲ Chronic sickness, physical or mental (too weak to work) ▲ Old – cannot work, and no money sent from children ▲ Not clever ▲ Widow without children's support

Source: Gilson 1998

In a Kenya study interviewers determined if a household was poor based on the following characteristics: appearance of living quarters or home, property (land, cattle, crops, other), education level of household members, number of children enrolled in school, or clothes and shoes worn (Newbrander et al., 1995).

In a sample interview from a Vietnam evaluation (see Annex C, from Ensor et al., 1996), questions were asked to draw out information regarding household income. It asked questions about household assets that were used as predictors or income. Questions were asked regarding various material possessions owned by the household, such as a television, radio, buffalo/oxen, thermos/vacuum flask, and electric lamp. Regarding income, the questionnaire asked the head of the household how much rice was cultivated, how much land is used to cultivate rice, how much rice was grown in the last two harvests, and how much rice the household retained. Questions on household debt and savings were also asked. To assess whether or not people received exemptions the questionnaire asked the Commune People's Committee if there were other ways of determining exemptions such as quality of clothes worn or weight of children (Ensor et al., 1996).

Most countries use both income and other criteria to determine who is poor. This is particularly important because income is difficult to verify in many settings. Whenever possible, the non-income criteria should be made as objective and clear as possible. Some countries (Kenya, Thailand) allow communities or health facilities to set the specific waiver criteria, within general guidelines.

6.4 Determining Who Authorizes Waivers

Because it is difficult to document income in many areas, and there are often other criteria to consider, determining who has authority for classifying the poor significantly affects the effectiveness of the targeting mechanism. There is a tradeoff in decentralizing authority to the community level – there is better information about who is poor, but the disadvantage is that waiver criteria may not be implemented consistently from community to community.

In Ghana the in-charges of the health facilities were responsible for identifying and screening waivers for individuals and their dependents (Garshong et al., 2001). It was found that when waiver decisions were made consistently by the same person or a "cohesive team," the implementation of exemption policies was more effectively carried out (Garshong et al., 2001). In a few health facilities those who knew the community, such as the watchman and the security guards, helped to evaluate and verify paupers. This finding was true also in Kenya where institutions with one individual was in charge of waivers were more consistent in applying eligibility criteria (Newbrander et al., 2000). However, many facilities do not have institutional arrangements for social welfare workers to identify poor patients (Bitran et al., 2001).

In Kenya, the waiver system allows each local institution to set the criteria it will apply in granting waivers and the chief executive at the facility has the authority in granting them. Social workers from the mission hospitals served as impartial intermediaries to assess who received waivers. They would visit the patient's home and the village chief before granting a waiver. This centralization of authority within a system that decentralized criteria-setting to health facilities made certain that the guidelines were implemented fairly and consistently within communities. (Newbrander et al., 1995; Newbrander et al., 2000).

In Thailand, health workers together with village committees help to determine who receives a Low Income Card, based on criteria established by the community. The village committee and village head review and decide who should receive a LIC, but the their recommendations are reviewed by the

sub-district health worker, and finally the LIC is issued from the district office. The system begins at the village level, but then requires district level approval.

The motivation of the person(s) granting the waiver must also be aligned with the goals of targeting the poor. Staff may be reluctant to grant exemptions due to a need (real or perceived) to collect revenues. When drug supply was dependent on revenue collection as in the case of Ghana, health workers granted limited exemptions, reducing access to care (Gilson et al., 1997). The same issue was noted in Papua New Guinea and Uganda (Gilson et al., 1997).

However, the person(s) granting the waiver should not be overly generous, creating leakage. In Zimbabwe, clerical staff are responsible for collecting or waiving payment. Clinical staff do not want to be involved and sometimes discourage the clerical workers from pressing for payment. The study found that many non-indigent are excused from paying fees (Hecht et al., 1992).

There is also evidence that waivers are granted sometimes as personal favors or for a fee. There was evidence from Thailand that waivers were granted for a fee, to relatives, or for political reasons (Gilson et al., 1998). It is particularly important to ensure some form of checks and balances to avoid this situation, as it further discourages the truly poor from applying for exemptions.

In most cases, the responsibility and authority for identifying the poor involved a team of individuals, usually including a health worker, rather than just one person. Involving many people adds to the complexity of administration, with the anticipated benefit of increasing effectiveness, although as yet there is no empirical data that confirm the benefits. It is important that the same person(s) approve all waivers, at least at the facility or community level. While decentralized screening seems to have advantages, clear guidelines whether from national or local authority are needed. Further, a mechanism for gathering data on the number of waivers granted, and allowing for verification of the individual's need, should be in place so that effectiveness of the system can be assessed.

6.5 Establishing Funding Mechanisms for the Poor

A key component of a successful waiver system for the poor is a concurrent mechanism to pay for the revenue foregone when providing services to the poor at no charge. In many countries, the staff concerns with raising revenue contributed to a reluctance to grant waivers.

In Zambia, the HCCS (Health Care Cost Scheme), which was set up to ensure that the poor have access to health care through fee waivers, does not consistently receive funds to cover this segment of the population. This funding failure is partly due to insufficient funding, and partly due to lack of clarity in funding procedures. The district health management teams were to provide an account of the number of poor treated to the Social Welfare Offices, who would remit funding to the DHMTs. This procedure was rarely followed (Kakuwa, 1997). At the same time, the Social Welfare Office was to issue certificates to the poor, and allocate funding to the DHMT based on the number of certificates issued. This procedure also does not appear to be followed (Masiye et al., 2000).

An evaluation of exemption practices in Ghana cited an increase in funding to compensate for waivers as a key recommendation. In Ghana, managers were not interested in providing waivers because of their growing dependence on user fee revenue (Nyonator et al., n.d.). In Kenya, health facility staff were reluctant to pass on information about waivers and believed the patient's relatives should assume the burden of fees because staff did not want to lose revenue (Bitran et al., 2001). Similar examples were also found in Indonesia and Zimbabwe (Bitran et al., 2001).

In contrast, Thailand does have systematic procedures for reimbursing care for LIC holders. It was estimated that in 1991, the budget allocation for LIC covered 75 percent of the actual cost of care, although there are issues with the equity of allocations across regions (Gilson et al., 1998).

In Indonesia, the budget to reimburse health providers for treatment of the poor is insufficient to fully replace the lost revenues. Health officials there limit the number of families that receive the Kartu Sehat, in order to minimize the loss of revenue (Gibbons, 1995).

The literature did not detail the specific flow of funds in different countries. An assessment in Zambia recommended decentralizing collection of HCCS funds to the facility (rather than the district) in keeping with government policies and encouraging community participation in protecting the poor (Kakuwa, 1997).

Health facilities that rely on revenue from user fees cannot be expected to grant waivers consistently and fairly unless there is funding to reimburse the facility for care provided, and clear procedures for accessing that funding.

6.6 Determining the Frequency of Waiver Certification

Once an individual or group has received a waiver status, the length of time that this status is valid should be defined. Health status, income, age, and employment, which change over time, are all factors that influence whether a waiver is granted. Periodic verification and re-certification are necessary components of an exemption policy, as recommended by Newbrander (2001), to avoid excess amounts of undercoverage and leakage. For example, an individual can lose his job or his income decreases so that he qualifies for waiver status. However, because there is no formal and regular period set for review, his change in status is not recognized and undercoverage occurs. Conversely, a person's income may significantly increase so that he can afford to pay for health services, but because there is no set review period, he continues to take advantage of his waiver status, thus creating leakage.

The status of employment and income tend to fluctuate often for the poor, making frequent assessment of their exemption status necessary, although expensive (Bitran, 2001). It is important to balance the frequency of review so that it is not too often (expensive), and not too infrequent (creating undercoverage and/or leakage). In countries where cards are issued to identify eligibility, a period of validity should be noted on the card.

The cost of determining whether a person is eligible for a waiver would argue against waivers by episode of illness at the primary care level, although it may be appropriate at the hospital level, where much higher expenses are involved. The literature did not provide country specific discussions on the frequency of waiver certifications.

Based on the information above, standards of practice need to be established in order for a waiver system to function and fulfill its objective of protecting to the poor. Tools to consistently and appropriately identify the poor, with criteria that allow for adaptation and flexibility at all levels (hospitals, districts, and health facilities, etc.) need to be created. Setting income and non-income categories that reflect a country's economic environment and culture are also essential. Determining the correct person(s) to identify beneficiaries has also been cited as a weakness in many countries, and should be a priority during policy and design discussions. Simultaneously, adequate financial and administrative resources must be committed to fully sustain a waiver mechanism.

7. Key Implementation Components

The literature documented many factors constraining effective implementation of exemption and waiver policies. They range from lack of information to weak administration to cultural issues. Table 6 shows the range of implementation issues faced, some of which can be addressed through design elements, others of which require increased implementation support.

Table 6: Constraints to the Effective Implementation of Health Exemption Polices

Setting	Constraints to Effective Targeting
Information-scarce environments	▲ Household or individual income is difficult to assess, particularly in developing countries where salary or tax records are lacking, and where income may be erratic, seasonal, or in-kind ▲ Target group lacks information about their eligibility
Weak administration	▲ Lack of procedural guidance or support to exemption administrators within facilities ▲ Staff responsible for exemptions are untrained and face time constraints ▲ Failure to monitor and adjust exemption practice where necessary ▲ Lack of coordination between agencies responsible for exemption implementation
Economic constraints	▲ Inadequate budget resources allocated to finance exemptions ▲ Reluctance of staff to grant exemptions because undermines revenue generated
Socio-cultural and political constraints	▲ Eligibility for exemptions granted to more privileged groups ▲ Social and political pressure on those issuing exemptions to accept bribes or waive fees for kin and friends ▲ Reluctance of the poor to accept exemptions due to stigma and invasive bureaucratic procedures ▲ Lack of accountability to the poor of health committees or other decision-makers responsible for exemption design and implementation

Source: Gilson, 1998

Throughout the literature, several key elements influencing effective implementation were mentioned, as discussed below:

7.1 Education of Health Workers (or Others Involved)

Health providers must have training on how to implement exemptions and knowledge of the program so that it may be effective. Training helps the provider understand not only the purpose of exemptions, but also who is eligible and how to maintain and use data for monitoring purposes. In Kenya the problem of accurately identifying a person's ability to pay at high-volume facilities stemmed from health workers who were not trained with the appropriate skills: "while most automatic exemptions (according to patient age or service used) are applied uniformly, waivers for the poor are applied infrequently and inconsistently" (Gilson et al., 1997). In some cases, it was found that the officer-in-charge "was unaware of the proper procedure for application and approval of waivers…[and] did not realize he had the authority to approve waivers" (Newbrander et al., 1995).

In Zambia, "exemptions had been introduced without sufficient thought about how to implement them," and the Ministry of Community Development and Social Services were not administratively or financially capable of implementing the policy (Gilson et al., 1997). It was identified that members for the Ward Welfare Committees, District Welfare Committees and DHMTs were not fully aware of the purpose of the Health Care Cost Scheme. The Ward Welfare Assistance Committee (WWAC) is responsible for identifying and selecting members within their ward to qualify under the scheme. However, those who were chosen did not always qualify under the established HCCS guidelines (Kakuwa, 1997). Health workers were unsure of the definition of the poor as defined in the MCDSS guidelines (Masiye et al., 2000). It was also found that some health workers were "reluctant to grant exemptions or [gave] the poor inferior care," and that health workers were not assisting applicants for waivers (Masiye et al., 2000).

Different types of training and information may also be necessary for the various levels of health care facilities from the central government to the communities. Training and education might address not only the policy and procedures, but also the provider attitudes toward waivers, which were found to affect implementation in Ghana (Garshong et al., 2001). A coordinated effort to maximize the flow of information and ensure consistency in implementation and coverage between communities is also essential.

Educating health workers on the purpose, intent and implementation of waivers needs to be improved in many countries where they are responsible for granting exemptions. Presently, inconsistent behavior from health workers, due to lack of training and explicit guidelines, has contributed to the current problems in implementing waiver mechanisms.

7.2 Information Campaign for the General Public

Many country examples and surveys note that communities and the general population generally lack enough information about waivers to take advantage of the policies. They lack knowledge about what exemptions and waivers are, who is eligible to be exempted, what the exemptions cover, and how to obtain exemptions and waivers. Many who would qualify for waivers are unaware of such programs and the free services for which they may be eligible.

In Zambia, there was no formal communication campaign before HCCS was implemented. Apart from MOH circulars transfer of information was very informal. A household sample in Zambia found that only 60 percent were aware of the HCCS scheme (Masiye et al., 2000). Another study found that those who lived further away from health facilities were even less knowledgeable of the HCCS scheme (Kakuwa, 1997). It was found that those located within 10 kilometers of a health

center had a 28 percent probability of using services, while those living further than 10 kilometers only had a 13 percent probability, which would imply that the health center cannot be relied upon as the source for information dissemination (Diop et al., 1998). In future attempts to inform the poor, health workers, communities, and various committees, an effort should be made to concentrate on health centers and word-of-mouth to transfer information, which a number of studies have found to be the most common routes of communication (Masiye et al., 2000; Newbrander et al., 1995). However, it is important that dissemination not rely solely on health center staff.

There was also not a formal information campaign about exemptions in Kenya, where patients obtained knowledge by word-of-mouth from concerned staff, family members and friends. These were "…primary sources of information" on exemptions (Newbrander et al., 1995).

Knowledge of exemptions and waivers varied by socio-economic group, with 72 percent of the poor saying that the poor must pay, versus only 33 percent of the non-poor; it was also found that the urban population was more aware of waivers (Newbrander et al., 1995). The Kenya report noted the exemption portion of the system is working well at the government health facilities because patients are easily identified by certain characteristics allowing them to receive free health care. The data shows, nonetheless that in most cases, fewer than half the population are aware of specific exemption categories. In Zimbabwe only half of the population had heard of the waiver system (Bitran et al., 2001). Thus, extensive education of the general public should be a key component of any implementation plan.

Table 7: Interviewees Knowing the Following Categories are Exempted from Fees

	Percentage positive responses %	
Exemption Category	**Kenya**	**Tanzania**
Children under 5 years of age	63	13
MCH Services	n/a	5
Child Health Clinic	48	n/a
Family Planning	39	n/a
TB patients	15	7
Leprosy patients	2	5
Polio patients	n/a	4
Typhoid patients	n/a	9
Cancer patients	n/a	6
AIDS patients	15	4
Elderly patients	15	2

Source: Newbrander et al., 1995, 1996

The experience from Kenya may support more formal information dissemination mechanisms to inform the public about exemptions and waivers. A public information campaign may need to overcome other stigmas associated with waivers. Barriers to obtaining waivers included not only "lack of information about eligibility for free care," but also "the perceived difficulty of obtaining a subsidy at the health service facility and fear of being charged; and the stigma of claiming a subsidy. Respondents suggested that users in Fiji, Namibia, and Thailand were unwilling to identify themselves as poor" (Gilson et al., 1997).

In Thailand the LIC scheme allowed the poor to receive identification cards enabling them to receive free care at public health facilities. During the allocation process a general public information campaign disseminated eligibility criteria, the application process, and the location and timing through different media such as radio, local newspapers, posters, and press conferences (Gilson et al., 1998). Other means of dissemination are village meetings (Gibbons, 1995).

While many users will obtain information through informal mechanisms, more formal campaigns can increase awareness about waivers, including specific eligibility criteria and the application process. Formal campaigns can also ensure that information is disseminated accurately, reinforce the messages to health workers and others involved, and can even be used to de-stigmatize waivers.

7.3 Establishing Simple Administrative Procedures

The process of applying for a waiver must be kept simple for both the patient and the health provider. Qualified patients may not take advantage of the waiver if it is burdensome to obtain. Health workers may try to limit the granting of exemptions if it significantly increases their workload.

To be exempted for health services Zambians must go through a registration process if they do not automatically fall with the under age 5 or over age 65 categories. This is especially difficult for the very poor in terms of opportunity costs. To register for certification the poor must travel to the district social welfare office to apply for exemption. Many of the offices are located in areas that are not easily accessible. Between travel costs and follow-up, the benefit of acquiring an exemption status is not always viewed as a priority. For those who rely on begging and peddling to acquire income, sacrificing any time away from their livelihood is not easily justified. The application process can also take up to six months to complete (Masiye et al., 2000).

In Zimbabwe it was suggested that the administration of determining eligibility for free care should be kept simple for implementation purposes. One recommendation was reducing the number of categories of exemptions. The MOH's policy uses clerical staff to determine eligibility based on employment status and place of residence. The clinical staff feel uncomfortable helping with these decisions and have influenced the clerical workers to be more liberal with giving exemptions creating a leakage issue (Hecht et al., 1992).

The administrative cost of granting waivers should be kept low for services with low fees, while more complex review can be used for higher cost services, such as inpatient services (Newbrander et al., 2000).

Many studies highlighted the need for simple and efficient registration procedures, eligibility guidelines, and benefit access. Both beneficiaries and implementers would make greater use of waivers if administration were simplified.

Box 1: Examples of Administrative Processes

Thailand Low Income Card Allocation Process

The Low Income Card (LIC) scheme involves several actors in the decision making process. Not only are the health workers given a voice in determining who receives a card, the village committee, the sub-district level, or *Tambon,* health worker, a rural development worker, and an agricultural officer (both recently added to the village committee to strengthen its knowledge about eligibility), are all part of the goal to provide coverage to qualified individuals and families in Thailand.

The village committees role in the screening process was strengthened to address criteria inconsistencies in granting exemptions by the Ministry of Interior. It gives them a stronger voice in the process than the village head. Health workers are responsible for checking the village Tambon's list of eligible candidates, and have the power to remove people from the list. The village head is responsible for going house to house to encourage people to apply one month before the deadline and to inform them of interview dates. In addition, the village health volunteer assists in conducting interviews to facilitate the application process.

The applications are collected by the village head, who then passes them onto the village committee. The committee and the village head review and decide who should receive a LIC. The final list is then passed onto the Tambon level where it is further reviewed and given to the district office. The district office then creates the cards and gives them to the village head to distribute them to the accepted applicants.

There were variations on how information was disseminated and how LIC applications were determined. Both the province and district levels discussed the card allocation process in their monthly meetings and distributed applications. However, neither provided any detailed information or direct supervision to subsequent levels of the allocation process. Nor was it given any special emphasis.

Information was distributed to potential applicants to the villages and Tambons. The municipalities (urban area) used a variety of means for dissemination through loudspeakers, banners, slide shows, print advertisements and TV.

The village and Tambon level made announcements by loudspeaker a month prior to the application day although the information varied from the two communities surveyed. The village head and the deputy made an effort to notify those they knew who were poor to apply for the card. The village leaders and health workers assisted the applicants in completing their forms. The application process also varied from one community to another. Some were required to show household registrations, some village heads used other criteria to justify allocation of a card, while on the municipality level the review process was mostly bypassed and all applicants were granted a card.

Source: Gilson, 1998

7.4 Establishing Monitoring and Evaluation Systems

Even in spite of sound design and implementation, ongoing monitoring is required to ensure that waivers produce the desired effects. Poor monitoring and evaluation was cited in many of the studies including Ghana, Zambia, Kenya, Tanzania, and Thailand (Garshong, Masiye, Kakuwa, Newbrander, and Gilson, respectively). Information on number of exemptions issued, category and reasons for exemption, health facility information, area served, and background information on the patient contribute to a good evaluation system. Systems must be in place to record the volume of waivers and exemptions and their value (Newbrander et al., 2000). In the Gilson and Newbrander studies, setting up monitoring systems are recommended to measure the effectiveness of exemption policies.

A study of Zambia's exemption system found that 28 percent of the individuals receiving exemptions did not meet the age or diagnosis criteria (Diop et al., 1998). Further, the individuals wrongly given exemptions tended to be higher income (Diop et al., 1998). Masiye and Odegaard's

study found that Zambia's HCCS had limited impact on the poor and also produces substantial leakage of benefits (2000). Thus, routine monitoring and evaluation is needed to identify problems or unintended outcomes, so modifications to design and implementation can be made to address the issues.

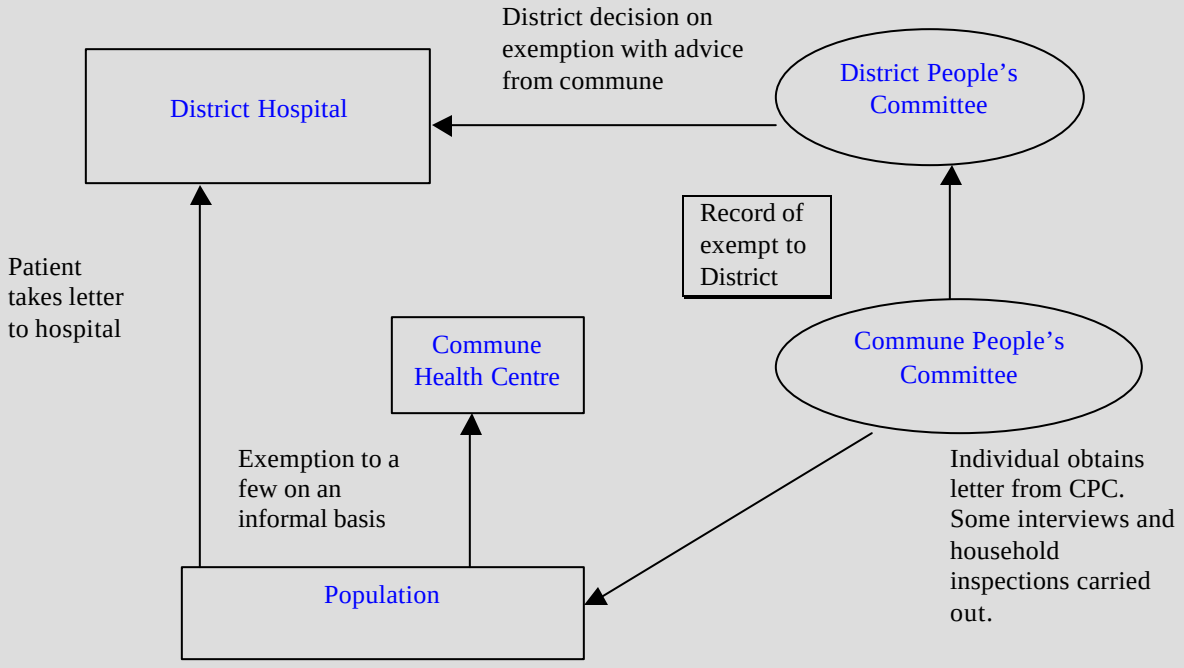
Box 2: Examples of Administrative Processes

Vietnam's Exemption Process

The commune government lists with a number of categories where specific individuals would qualify for exemptions: the invalid or disabled, families who lost a son during the war, the elderly, poor and those who have had a bad harvest. These categories are similar between communes.

The commune uses its own tax and income information to determine eligibility. This information is collected by commune and hamlet workers. Interviews and family inspections are conducted if there is a question regarding the status of a household. Means testing is not relevant in most cases since most waivers are based on physical characteristics. When means testing is used, it is based on crude measures like a person's clothes or the state of his dwelling.

For care required outside of the commune, records are sent of recommended people for exemptions to the district hospital or District People's Committee. A letter from the Commune People's Committee (CPC) must first be obtained before free treatment can be provided. Communes cover the exemption costs at the health center and the districts cover the costs at the hospital (Ensor et al., 1996).



8. Conclusions

The literature review did not reveal empirical data regarding how to implement waivers (need-based exemptions) most effectively. Systems for monitoring the effectiveness of waivers are weak, and few evaluations have been done. The evaluations that have been done focus on qualitative information about the implementation process, which is the focus of this paper, rather than on quantitative analysis of implementation components and effectiveness. Given the information constraints, several conclusions are generally supported by the literature:

- There must be clear and simple waiver policies and guidelines for granting waivers to the poor. The guidelines should be set at the national level to ensure adequate consistency between districts and communities, while providing sufficient flexibility at the sub-national levels to be locally applicable and accepted.

- Resources must be dedicated for educating the beneficiaries and health staff on the waiver policies. Lack of clarity and knowledge was an issue cited in nearly every study published and should be a key component of any implementation plan. Dissemination of policies and procedures to consumers must include a variety of communications channels, not relying solely on health facilities and their staff.

- The lack of a reliable funding source to pay for the services provided to the poor negatively impact the motivation (and sometimes financial ability) of health staff and health facilities to grant waivers. Given funding constraints, it may be necessary to limit the number of waivers granted, or to provide guidance on the percentage of the population that can be granted waivers, in order to ensure adequate funding for services provided to the poor.

- There is a tradeoff between undercoverage and leakage, and neither is completely avoidable. Policies can be established that encourage erring on one side or the other. Communication of clear policies to all involved, and a mechanism for regular evaluation, can help to minimize undercoverage and leakage.

- Using multiple targeting methods may be a more efficient way to administer a targeting program and achieve desired outcomes. Using geographical targeting (characteristic) to identify lower income areas, combined with direct targeting within those areas may allow relatively high accuracy at relatively low cost.

- Means testing should be used only in waiving fees for high cost services, because there is a high administrative cost. Waivers should be discouraged for low-cost services, relying on exemptions to ensure access to services.

- Once an individual is granted a waiver status, there should be a clear policy regarding the duration for which the waiver status is valid. Setting a regular review period helps to minimize leakage and undercoverage.

- Routine monitoring and evaluation is required to ensure that a system has the intended

outcomes, particularly with respect to the level of leakage and undercoverage. Ongoing implementation and design changes may be required to ensure that the poor are adequately covered.

Based on the literature, there are many problems with the current state of the waiver system in Zambia, including lack of knowledge by health workers and the general public, lack of clear implementation guidelines (how to define the poor, who has authority to waive the fee), lack of a mechanism for compensating providers for lost revenue, and lack of a monitoring and evaluation system. In addition to the conclusions above, recommendations are offered for Zambia as it reconsiders the future of its waiver policy:

- Determine the extent to which characteristic exemptions are covering the poor at the primary health care level. Based on that data, determine whether waivers should continue to be implemented at the primary care level and what is required to strengthen the waiver system, or whether the waiver system should be discontinued at the primary care level.

- Commit resources to providing health care for the poor by setting aside a budget for reimbursing health providers for care to the poor. Based on the budget available, determine the number of people or percentage of the population that can be granted waivers. If the budget is limited, consider implementation in a limited area.

- Prepare a plan for implementation, and commit funding to implementation activities. The evidence shows that mere statement of policies does not produce the desired results in any country studied.

Annex A: Examples of Possible Exemptions

Population	▲ Children under 5 ▲ Pregnant women ▲ Armed forces ▲ Civil servants ▲ Elderly patients ▲ By occupation ▲ Residence in a particular geographical area ▲ Psychiatric patients (Ghana)
Illnesses and Diseases	▲ TB ▲ AIDS ▲ Leprosy ▲ Yaws (Ghana) ▲ Cholera (Ghana) ▲ Buruli ulcer (Ghana)
Exempt outpatient services (from the Kenya exemption policy):	▲ Child health or welfare clinics ▲ Antenatal and postnatal clinics ▲ Family planning visits ▲ Sexually transmitted disease clinics
Exempt inpatient services (from the Kenya exemption policy):	▲ After 14 days of inpatient care, patients are exempt from further charges (this applies only toward fees not laboratory or x-ray fees) ▲ Downward inpatient referrals from higher to lower level facilities ▲ Upward inpatient referrals from lower to higher level facilities; time spent in lower level facilities count toward the 14 day maximum inpatient charge limit; exemptions do not apply for referrals to the national tertiary hospital, Kenyatta National Hospital (KNH).

Annex B: Exemption Rules for Ministry of Health Institutions, Kenya

Exemption Rules for Ministry of Health Institutions, Ministry of Health, Government of Kenya Health Care Financing Project
EXEMPTION RULES FOR MINISTRY OF HEALTH INSTITUTIONS
1 October 1994

NOTES:

1. In the case of financial hardship, patients should be considered for a waiver according to laid down procedures.

2. There are no exemptions from inpatient fees for National Hospital Insurance Fund (NHIF) beneficiaries. A claim should be submitted for all NHIF beneficiaries, even if the patient is exempt under any of the following rules.

EXEMPTION RULES:

1. Exempt patients - The following group of patients are exempted from paying Facility Improvement Fund fees of all types except where indicated otherwise:

- Children 5 (five) years of age and under (outpatient fees only)
- Inpatients readmitted for the same episode of illness within 14 days of discharge
- Patients from charitable and destitute homes and from homes for mentally handicapped
- Prisoners and all other persons in police custody
- Unemployed persons who present written certification by their District Officer (valid for six months, after which certificate must be renewed.

2. Exempt outpatient services - Outpatients seen at any of the following outpatient clinics are exempt from outpatient treatment, laboratory and X-ray fees:

- family planning
- antenatal and postnatal clinic
- child welfare clinic – also exempt by virtue of age
- STD clinic

3. Exempt Illnesses - Patients with any of the following illnesses are exempt from any Facility Improvement Fund fee related to treatment and follow-up of their primary illness. This exemption includes outpatient services, inpatient services, and necessary investigation of the following illnesses:

- Antenatal complications of pregnancy
- Tuberculosis (TB) and leprosy
- AIDS

NOTE: Patients with other chronic diseases (e.g., psychiatric illness, diabetes, epilepsy, asthma) and emergency cases (e.g., RTA) are NOT automatically exempt. For financial hardship cases, fees should be waived following the laid down procedures for long-term waivers of the chronically ill.

4. Exempt inpatient services

- After 14 days, inpatients are exempt from daily patient charges, but NOT from X-ray or laboratory fees. There is no limit on the number of chargeable inpatient days at KNH.
- 'Downward' referrals of inpatients from KNH, provincial hospitals, and district hospitals for recuperation (with supporting documentation from the referring facility)
- For 'upward' referrals of outpatients to provincial, district, and sub district hospitals (but not KNH), the maximum number of inpatient days charged includes the inpatient days at referring hospital and at the receiving hospital.

Annex C: Questionnaire on Health Charges and Exemptions, Vietnam

I would now like to ask you some general questions about your household and the dwelling in which you live?

a) Household assets

6.1 Does your household own any of the following assets in working order (please circle)?

	Yes	No
Thermos/vacuum flask	1	2
Bicycle which works	1	2
Motorcycle which works	1	2
Radio - without cassette recorder which works	1	2
Radio - with cassette recorder which works	1	2
Television which works	1	2
Car/van/truck which works	1	2
Fridge which works	1	2
Fan which works	1	2
Set of table and chairs (salon)	1	2
Buffalo/oxen	1	2
Engine which works	1	2
Electric lamp which works	1	2

b) Dwelling

I am now going to ask you some questions about the dwelling that you live in.

6.2 When was this dwelling built	Year..... Don't know	..... -9
6.3 What type of roof does the dwelling have?	Concrete. Tiled..... Corrugated iron Other...	1 2 3 4
6.4 What are the walls of the dwelling made out of?	Concrete and brick Brick only Wood Mud Other	1 2 3 4 5

6.5 What is the floor of the dwelling made from?	Concrete Tiles Other	1 2 3
6.6 How many rooms does the dwelling have (excluding toilet and kitchen)?	Enter number	.....
6.7 Does the dwelling have a concrete yard?	Yes..... No.....	1 2
6.8 How does the dwelling obtain water for drinking?	Individual mains supply Communal tap Well Rain tank River or lake Other (please state) ...	1 2 3 4 5 6
6.9 What type of latrine does the dwelling have?	Water closet Double vault Composting pit other (please state)..... None	1 2 3 4 5

c) Occupation/income

These questions should be addressed to the head of household but concern the whole household.
I would now like to ask some questions about employment and income of the household

6.10 Does the household cultivate land for rice production?	Yes..... No.....SKIP TO QUESTION 5.15	1 2
6.11 How much land does your household is cultivate for rice?	Sao Don't know	..... -9
6.12 How much whole rice (in kilos) did you grow in the last two harvests?	Kilos of rice in last spring harvest Kilos of rice in last summer harvest Don't know	.... -9
6.13 Approximately how much did you spend on seed fertiliser, pesticides and other things such as hired labour during the last two harvests?	Amount in DONG Don't know	..... -9

6.14 How much of the rice grown was:		
retained for consumption by the household	KILOS.....	.....
paid in contribution to the commune	**(check that the sum of these equals total production and adjust if necessary)**	.....
paid in contribution to the hamlet		.....
paid in tax to the government		.....
sold for cash income		.....

6.15 How many members of the household receive a regular income from any type of employment other than rice production? ..... 6.16 For each member give their code number (from second page), activity, time spent on the activity each week, frequency of income collection and income collected. Up to three activities may be listed for each person but rice production should be excluded.

Code number of household member	Activity	Time spent each week	How often paid/frequency of income collection	Amount of income each time paid (Dong)

Coding: Activity: 1 Farming (other than rice) 2. processing of foods 3. fisherman 4. small business/crafts 5. government worker 6. Tradesman 7. other (please state).....

Time: 1. 5 days or more 2. 2-4 days 3. 1-2 days 4. fewer than 1 day a week

Frequency: 1. Daily 2. Weekly 3. Monthly 4. Seasonal (specify)... 5. other (specify)

d) Household savings

6.17 Does the household set any money aside?	Yes No....SKIP TO 5.22	1 2
6.18 What is the main way you keep this money?	Bank account Community fund Kept at house Purchase animals or land Send money to relatives Given to pay off debt Other (specify).....	1 2 3 4 5 6 7
6.19 How often do you put money aside?	Each month Only after harvest time Occasionally Other (specify).....	1 2 3 4
6.20 Approximately how much do you set aside each time?	DONG.....	.....
6.21 What is the main reason for which you set money aside?	In case of bad harvest To pay for children's education To pay future health fees To repay debt To help relatives To help buy extra land Save for household item Other (specify).....	1 2 3 4 5 6 7 8

e) Household debts

6.22 Does the household owe any money to anyone else at present?	Yes..... No.....SKIP TO 5.25	1 2
6.23 Who do you owe the money to? **(UP TO 4 MAY BE CODED)**	Friend or relative Bank Money lender Local co-operative Other (specify).....	1 2 3 4 5
6.24 For what purpose did you borrow the money? **(UP TO 4 MAY BE CODED)**	Pay school fees Buy household items Buy farm machinery Buy livestock Pay health fees Buy food Other (specify).....	1 2 3 4 5 6 7
6.25 How do you feel your household compares economically to other households in the commune?	Much poorer than average A little poorer than average About average A little better off than average Much better off than average Don't know	1 2 3 4 5 6

To interviewer: please summarise the response to the following question.

6.26 Finally I would like to ask what you think of the health care provided in the commune and what single improvement could be made to make the situation better?

Thank you very much for your assistance in answering these questions. I would like to assure you that all your answers will be treated in confidence.

Annex D: Respondents' Suggestions for Improving Implementation of Exemptions, Ghana

Suggestions and recommendations given by the various categories of respondents are summarized below (Garshong et al., 2000):

Users

- Increase public education on the policy and guideline.
- Encourage health providers to implement policy.
- Impose penalties on health providers who wrongly charge people.
- Monitor staff practices.
- Improve availability of drugs.
- Clarify policy.
- Introduce a user identification card system.

Health providers

- Revise policy to make it clearer.
- Simplify record keeping.
- Funds to be disbursed to the facilities up-front and not after submission of returns.
- Funds for exemptions to be kept at the DHMT.
- The implementation of the policy should be based on affordability.
- There should be a limit on amounts spent on exempt users.
- Reimbursement should be fast, regular and adequate to cover the cost of service.
- A good monitoring system should be put in place to check and verify the authenticity of the returns.
- Health providers and their dependants should be exempted from paying for services at any MOH facility.

- A health insurance scheme should be instituted to gradually replace the exemptions.
- Step up education of health providers to aid effective public education.
- MOH should decentralize the exemption funds and send funding directly to the district level.
- Auditing of returns should be carried out at the DHMT instead of the Audit Service.
- Monies should be sent directly from the Regional Health Administration into the institutional drug account.
- Credit facilities should be instituted at the regional medical store so that we can get our drugs and supplies whilst awaiting reimbursement.

District Assemblies

- Intensify public education on exemption policy.
- Involve district assemblies in the dissemination of information on the exemptions and monitoring.
- Target exemptions at deprived areas.
- Encourage community members, church leaders, and government appointees to be to be part of the exemption categorization process in their capacity as key community informants.

Private Providers

- Include private providers in the implementation of the exemptions, organize workshop to disseminate specifics of the guidelines to improve knowledge across all provider levels. Carry out repeated assessments to evaluate problems.
- Design an effective system to identify private providers who qualify to be part of the exemption policy implementation.
- Make policy clear-cut, with no ambiguities.
- Carry out reimbursements promptly.
- Ensure regular supply of drugs and other inputs.
- Have government provide special pharmacy shops for the exempted.
- Create public awareness about exemptions.
- Prioritize sustainability of the exemption policy.
- Phase out mass exemptions and introduce part payment of drugs for users in exempt categories.
- Provide exemptions in the deprived areas.

- Make financial status, rather than age, the key determining factor for setting up exemptions categories. Potential users exempt from payment to be determined by their community members, church elders, and government appointees.

- Allocate more money to family planning education, and charge for antenatal care.

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